Attach Recent Photo

IDENTIFYING INFORMATION

Date _____

Applicant's Full Name: _____
(First) (Middle) (Last) (Nickname)

Birth date: _____ Place of Birth: _____

Home Address:_____ Telephone: ( ) _____
(Street, Route or P.O. Box Number)

_____
(City) (State) (ZIP Code)

Mailing Address, If Different From Above: _____

Sex: _____ Race: _____ Hair Color:_____ Eye Color: _____

Identifying Marks: _____

Height: _____ Weight: _____ Social Security # _____

Citizenship: _____ Religious Preference: _____

Marital Status: _____ Languages Spoken/Understood: _____

Primary Diagnosis: _____

Legal Status: _____

Name and Address of Court Appointed Guardian: _____

_____ Telephone: ( ) _____

Date and Location of Competency Hearing: _____

Person Requesting Admission: _____

Relationship to the Applicant: _____

Reason for Request: _____

_____

Current Services Providers	Date Enrolled in Service
_____	_____
_____	_____
_____	_____

Financial Resources (type, amount, payee): _____

_____

Medical Insurance: _____, company _____

Policy#, _____, Type of coverage _____

Training centers operated by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services do not unlawfully discriminate against persons requesting admission on the basis of race, color, national origin, sex, religion, age, or disability. In compliance with the Americans with Disabilities Act, reasonable accommodations and ancillary aids will be provided upon request. Contact your regional training center regarding any special circumstance or need associated with accessing services.